North Carolina & Virginia

GENERAL SERVICE APPLICATION

Name: _____
DOB: _____
MR #: _____
Medicaid #: _____

RELEASE OF INFORMATION

Name: _____ DOB: _____ Record #: _____

I, _____ (Individual or Legally Responsible Person) hereby authorize Easter Seals UCP (ESUCP) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: _____ Agency (if any): _____

Address: _____

I further authorize the above named to share PHI with **Easter Seals UCP.**

Protected Health Information will be disclosed for the purpose of:

☐ Treatment ☐ Referral ☐ Payment ☐ Other: _____

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Discharge Summary
	Progress Note Documentation		Verbal Communication
	Alcohol/Drug Treatment Information*		Psychological Information
	Medical History and Physical		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure based upon it has already occurred. I understand that the information to be disclosed may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments.

I understand that the above recipient party may not release this information without my consent, and that once information is released, ESUCP has no control over the recipient's handling of that information.

This authorization will automatically expire on: _____ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

_____ _____
Signature of Person Served Date

_____ _____
Signature of Legally Responsible Person (if not self) Date

_____ _____
ESUCP Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered to be as valid as the original.

Program Office _____ **Contact Number** _____